Exhibit K

IN THE CIRCUIT COURT OF MADISON COUNTY, ALABAMA

IN RE:	§	
ALABAMA CT Scan Litigation	§	**MASTER FILE No. CV-2010-900111**
This Document Applies to All Cases	§	

PLAINTIFF'S FACT SHEET

You must complete this Fact Sheet if (1) you claim you were exposed to radiation during a CT scan on a CT scanner manufactured by General Electric Company ("GE"), (2) you are the representative of a person or the estate of a deceased person whom you claim was exposed to radiation during a CT scan on a GE CT scanner, or (3) you are bringing a loss of consortium claim arising out of your claim that your spouse or other family member was exposed to radiation during a CT scan on a GE CT scanner. Each individual asserting a claim must complete this Fact Sheet, even if multiple individuals assert claims pertaining to injuries allegedly suffered by the person allegedly exposed to radiation during a CT scan on a GE CT scanner.

In filling out this form, please use the following definitions: (1) "health care provider" means any hospital, clinic, medical center, physician, physician's office, technologist, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions.

In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this form. If you are completing the form for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. Pursuant to the Rules of Civil Procedure, you are required

to supplement your responses to this Fact Sheet if you discover additional or different information than what is contained in your responses herein.

CASE INFORMATION

Name of person completing this form: _____

Please state the following for the civil action that has been filed:

Case caption: _____

Civil Action No.: _____

Court in which action was originally filed: _____

Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

_____

_____

_____

If you are completing this questionnaire in a representative capacity (*e.g.*, on behalf of the estate of a deceased person or a minor), please complete the following:

Your Social Security Number: _____

Maiden or other names used or by which you have been known: _____

Address: _____

State which individual or estate you are representing, and in what capacity you are representing the individual or estate? _____

If you were appointed as a representative by a court, state the: Court: _____ Date of Appointment: _____

What is your relationship to the deceased or represented person, or person claimed to be injured? _____

If you are representing a decedent's estate, please state the date of death, the address where the decedent died, and the cause of death: _____

_____

_____

PERSONAL INFORMATION OF THE PERSON WHO CLAIMS EXPOSURE TO RADIATION DURING A CT SCAN

Name: _____

Maiden or other names used or by which you have been known: _____

_____

Social Security Number: _____

Address: _____

Identify each address at which you have resided during the last FIFTEEN (15) years, and list when you started and stopped living at each one:

Address	**Dates of Residence**

Driver's License Number and State Issuing License: _____

Date of Place and Birth: _____

Sex: Male ____ Female ____

Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	**Dates Attended**	**Course of Study**	**Diplomas or Degrees**

Employment Information:

Current employer (if not currently employed, last employer):

Name	**Address**	**Dates of Employment**	**Occupation/Job Duties**

List the following for each employer you have had in the last FIFTEEN (15) years:

Name	**Address**	**Dates of Employment**	**Occupation/Job Duties**

Are you making a wage loss claim for either your present or previous employment? Yes ____ No ____ ***If "yes,"*** state your annual income at the time of the injury/injuries alleged in Section IV(L): _____

Military Service Information: Have you ever served in the military, including the military reserve or national guard? Yes _____ No _____ ***If "yes,"*** were you ever rejected or discharged from military service for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No _____

Insurance/Claim Information:

Have you ever filed a worker's compensation and/or social security disability (SSI or SSD) claim? Yes ____ No ____ ***If "yes,"*** to the best of your knowledge please state:

Year claim was filed: _____

Nature of disability: _____

Approximate period of disability: _____

In the last 10 years, have you been out of work for more than 15 days for reasons related to your health (other than pregnancy)? Yes ____ No ____ ***If "yes,"*** set forth when and the reason. _____

_____

_____

_____

Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes ____ No ____ ***If "yes,"*** state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description of the claims asserted. _____

_____

_____

_____

As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes ____ No ____ ***If "yes,"*** set forth where, when and the felony and/or crime. _____

_____

_____

FAMILY INFORMATION

List for each marriage the name of your spouse; spouse's date of birth (for your current spouse only); spouse's occupation; date of marriage; date the marriage ended, if applicable; and how the marriage ended (*e.g.*, divorce, annulment, death): _____

_____

_____

_____

Has your spouse or any other family member filed a loss of consortium claim in this action? Yes ____ No ____ ***If "yes,"*** state the name of your spouse or family member(s) filing

the loss of consortium claim and their relationship to you. _____

_____

To the best of your knowledge, has any child, parent, sibling or grandparent of yours been diagnosed with any form of cancer? Yes _____ No _____ Don't Know _____ ***If "yes,"*** identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Cancer: _____

If Applicable, Cause of Death: _____

To the best of your knowledge, did any child, parent, sibling, or grandparent of yours suffer from any of the following: diabetes, heart attack, high cholesterol, high blood pressure, blood clots, coronary artery disease, congestive heart failure, deep vein thrombosis, transient ischemic attack, or stroke? Yes _____ No _____ Don't Know _____ ***If "yes,"*** identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Problem: _____

If Applicable, Cause of Death: _____

If applicable, for each of your children, list his/her name, age and address:

_____

_____

_____

_____

If the person who was allegedly injured as a result of being exposed to radiation during a CT scan is deceased, list any and all heirs of the decedent:

_____

_____

_____

_____

Are there persons (other than those already identified in this Fact Sheet) you believe are witnesses to your claimed injuries or the damages? If so, please provide their name and address:

_____

_____

_____

CT SCAN CLAIM INFORMATION

For the injuries you claim in this case, please identify the type of CT scan(s) you believe you received (*e.g.*, cardiac, diagnostic head, brain perfusion, abdomen) and the date or dates on which you received the scan(s)?

Scan Type _____ Date: _____

For each scan identified in response to Section IV.A, identify the manufacturer of the CT scanner performing the scan and how you determined the identity of the manufacturer:

_____

_____

Who was your treating physician(s) during the hospitalization in which you received the CT scan(s) identified in response to Section IV.A? **Please provide the full name and address of the treating physician.** _____

_____

_____

_____

Who prescribed the CT scan(s) that you identified in response to Section IV.A.? **Please provide the full name and address of the prescriber.** _____

_____

_____

Who was the radiologist and technician for the CT scan(s) that you identified in response to Section IV.A.? **Please provide the full name and address of the radiologist and technician.** _____

_____

_____

_____

To your understanding, for what condition(s) was the CT scan(s) that you identified in response to Section IV.A. ordered?

_____

_____

Did you have a series of CT scans? Yes _____ No _____ Don't Know _____ ***If "yes,"*** identify each scan ordered in the series of scans. _____

_____

To your knowledge, were any of the same CT scans performed more than once (*i.e.*, the same scan was repeated) on the same date? _____

_____

Please identify the CTDIvol and DLP shown on the dose report for the CT scan(s) that you identified in response to Section IV.A: _____

_____

Instructions or Warnings:

Did you receive any written or oral information about CT scans or radiation dose before the CT scan(s) were performed? Yes _____ No _____ Don't Recall _____

Did you receive any written or oral information about CT scans or radiation dose after the CT scan(s) were performed? Yes _____ No _____ Don't Recall _____

If "yes," to either 1 or 2,

When did you receive that information? _____

From whom did you receive it? _____

What information did you receive? _____

_____

Are you claiming that you have suffered or may develop bodily injury/injuries as a result of exposure to radiation during the CT scan(s) that you identified in response to Section IV.A.? Yes _____ No _____ ***If "yes,":***

What are the bodily injury/injuries you claim resulted from your exposure to radiation during the CT scan(s) that you identified in response to Section IV.A. (please include all injuries claimed)? _____

_____

_____

Who, if anyone, diagnosed your condition(s) that you claim is associated with your exposure to CT scans? _____

_____

Has any health care provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe above are due to exposure to radiation resulting from the CT scan(s) that you identified in response to Section IV.A.? Yes _____ No _____ ***If "yes,"*** then state and describe:

What you (or your agents, representatives or anyone acting on your behalf) were told: _

_____

Who told you (or your agents, representatives or anyone acting on your behalf) and when: _____

Have you ever suffered this type of injury/injuries prior to the date set forth in answer to the prior question? Yes _____ No _____ ***If "yes,"*** when and who diagnosed the condition(s) at that time? _____

_____

_____

Do you claim the exposure to radiation during the CT scan(s) that you identified in response to Section IV.A. worsened a condition(s) or injury that you already had or had in the past? Yes ____ No _____ ***If "yes,"*** set forth the injury or condition; state how you allege the CT scan worsened the injury or condition; whether or not you already recovered from that injury or condition before you were exposed to radiation during a CT scan(s) that you identified in response to Section IV.A.; and the date of recovery, if any. _____

_____

_____

_____

Are you claiming mental and/or emotional damages as a consequence of the CT scan(s) you identified in response to Section IV.A.? Yes ____ No ____ ***If "yes,"*** for each provider (including, but not limited to a primary care physician, psychiatrist, psychologist, counselor, or therapist) from whom you have sought treatment for psychological, psychiatric or emotional problems during the last FIFTEEN (15) years, state:

Name and address of each person who treated you: _____

_____

To your understanding, the condition(s) for which you were treated:

_____

When treated: _____

Medications prescribed or recommended by provider: _____

COMMUNICATIONS WITH HEALTHCARE PROVIDER

Have you ever had any communication with a Healthcare Provider employee or representative related to CT scans? Yes _____ No _____ Don't Recall _____ ***If "yes,"***

Who?

_____

When?

_____

To the best of your ability, please describe the communication with a Healthcare Provider employee(s) or representative(s)?

Have you ever received any documents or information directly from a Healthcare Provider related to CT scans?
Yes _____ No _____ Don't Recall _____ ***If "yes,"***

From whom did you receive the documents or information?

When did you receive the documents or information?

Who gave you the documents or information?

Do you still have the documents or information?

If you no longer have the documents or information in your possession, or the information was oral, to the best of your ability, please describe the documents or information that you received.

COMMUNICATIONS WITH GE

Have you ever had any communication with a GE employee or a GE representative related to CT scans? Yes _____ No _____ Don't Recall _____ ***If "yes,"***

Who?

When?

To the best of your ability, please describe the communication with a GE employee(s) or representative(s)?

Have you ever received any documents or information directly from GE related to CT scans?
Yes _____ No _____ Don't Recall _____ ***If "yes,"***

From whom did you receive the documents or information?

_____

When did you receive the documents or information?

_____

Who gave you the documents or information?

_____

Do you still have the documents or information?

_____

If you no longer have the documents or information in your possession, or the information was oral, to the best of your ability, please describe the documents or information that you received.

_____

_____

_____

MEDICAL BACKGROUND

Height: _____

Current Weight: _____

Weight at the time of the injury, illness, or disability described in Section IV.L.: _____

Smoking/Tobacco Use History: Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.

___ Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
___ Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
  a. Date on which smoking/tobacco use ceased: _____
  b. Amount smoked or used: on average _____ per day for _____ years.
___ Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
  a. Amount smoked or used: on average _____ per day for _____ years.

Drinking History: Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ____ No ____ ***If "yes," fill in the appropriate blank*** with the number of drinks that represents your average alcohol consumption during the past FIFTEEN (15) years:

___ drinks per day,
___ drinks per week,
___ drinks per month, ***or***
Other (describe): _____

Illicit Drugs: Have you ever used (even one time) any illicit drugs of any kind within one (1) year before, or any time after, you received the CT scan(s) where you claim you were over-exposed to radiation?" Yes ____ No ____ Don't Recall _____ ***If "yes,"*** identify each

substance and state when you first and last used it. _____

_____

_____

_____

Have you ever been screened for and/or diagnosed with any form of cancer? Yes ____ No ____ Don't Know _____ ***If "yes,"*** provide the following information:

Condition	**When**	**Treating Physician**	**Hospital**

To the best of your knowledge, during the past FIFTEEN (15) years, have you ever suffered from or been diagnosed by a doctor or other health care provider with:

	Yes	No	Don't Recall
High cholesterol	___	___	___
Hypertension/high blood pressure	___	___	___
Obesity	___	___	___
Diabetes	___	___	___
Neuropathy	___	___	___
Thyroid disorder	___	___	___
Autoimmune disease (including HIV or AIDS)	___	___	___
Congestive heart failure	___	___	___
Myocardial infarction (MI), heart attack, or other heart disease	___	___	___
Stroke or transient ischemic attacks (TIAs)	___	___	___
Chronic obstructive pulmonary disease (COPD) or other respiratory disorder	___	___	___
Liver disease or jaundice	___	___	___
Metabolic syndrome	___	___	___
Enlarged prostate	___	___	___
Arteriosclerosis (hardening of the arteries) or other vascular disease	___	___	___
Kidney failure or other kidney disease	___	___	___
Cataracts	___	___	___
Hair Loss	___	___	___
Depression or Psychiatric Issues	___	___	___

If you answered "yes" to any of the conditions above, provide the following information for each condition:

Type of Condition	**Date of Diagnosis**	**Diagnosing Doctor**

Please list each time you have been hospitalized over the past FIFTEEN (15) years:

Date	Name of Hospital	Reason for Hospitalization

Exposure To Pesticides, Solvents, Fibers, Dioxins, Lead, Metals, Hydrocarbons and other potential Carcinogens: Have you ever been employed or otherwise been in an environment that exposed you to pesticides, solvents, fibers, dioxins, lead, metals, hydrocarbons, or other potential carcinogens? (*e.g.*, have you worked with pesticides, paint thinners, paint, grease removers, dry cleaning chemicals, asbestos, chlorine, hydrocarbons, lead acetate, lead phosphate, gasoline and diesel exhaust, etc.). Yes ____ No ____ Don't Recall _____ ***If "yes,"*** identify each substance and the circumstances around your exposure. _____

_____

_____

_____

Have you ever been diagnosed with any of the following viruses and bacteria: human papillomavirus (HPV), hepatitis B or C, Epstein-Barr virus (EBV), Kaposi's sarcoma-associated herpesvirus (KSHV), human herpesvirus 8 (HHV-8)? Yes ____ No ____ Don't Know _____ ***If "yes,"*** provide the following information:

Virus/Bacteria	When	Treating Physician	Hospital

Please indicate to the best of your knowledge whether you have ever received any of the following treatments or diagnostic procedures:

Treatments/interventions for any form of cancer:

Treatment/Intervention	When	Treating Physician	Hospital

Surgeries, including, but not limited to, the following, and specify for what condition the surgery was performed: open heart/bypass surgery, pacemaker implantation, vascular surgery, IVC filter placement, carotid (neck artery) surgery, brain surgery:

Surgery	Condition	When	Treating Physician	Hospital

Treatments/interventions for heart attack, angina (chest pain), atherosclerosis, coronary artery disease, lung ailments, esophageal (throat) ailments, gastric (stomach) problems, intestinal problems, or renal problems, including but not limited to cardiac catheterization, atherectomy, angioplasty/balloon/stenting, and dialysis:

Treatment/Intervention	When	Treating Physician	Hospital

To your knowledge, have you had any of the following tests performed: X-ray, PET/CT, fluoroscopy, CT scan (other than those identified in Section IV(A)), angiogram, MRI, MRA, EKG, cardiogram, TEE (trans-esophageal), endoscopy, lung bronchoscopy, bone scans, nuclear medicine exams, carotid duplex, ultrasound, bubble/microbubble study, or Holter monitor? Yes _____ No _____ Don't Recall _____ ***If "yes,"*** answer the following:

Diagnostic Test	When	Treating Physician	Hospital	Reason

LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

Your current family and/or primary care physician:

Name	Address

To the best of your ability, identify each of your primary care physicians for the last TEN (10) years:

Name	Address	Approximate Dates

Each hospital, clinic, health care facility, or health care provider where you have received inpatient treatment or been admitted as a patient during the last TEN (10) years:

Name	Address	Admission Dates	Reason for Admission

Each hospital, clinic, health care facility, or health care provider where you have received outpatient treatment (including treatment in an emergency room) during the last TEN (10) years:

Name	Address	Admission Dates	Reason for Admission

Each physician or health care provider from whom you have received treatment in the last TEN (10) years:

Name	Address	Dates of Treatment

Each pharmacy that has dispensed medication to you in the last TEN (10) years:

Name	Address

If you have submitted a claim for social security disability benefits, state the name and address of the office that is most likely to have records concerning your claim:

Name	Address

If you have submitted a claim for worker's compensation in the last TEN (10) years, state the name and address of the entity that is most likely to have records concerning your claim:

Name	Address

DOCUMENTS

Please indicate if any of the following documents and things are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers by checking ***"yes"*** or ***"no."*** Where you have indicated ***"yes,"*** please attach the documents and things to your responses to this fact sheet.

All documents you or anyone acting your behalf reviewed in preparation of this Fact Sheet.
Yes ____ No ____

Records of physicians, hospitals, pharmacies, and other healthcare providers identified in response to this Fact Sheet. Yes ____ No ____

To the extent not included in the foregoing, all records relating to any examination of the individual exposed to radiation by a physician or other health care provider, conducted for any purpose during the past FIFTEEN (15) years. Yes ____ No ____

If the individual exposed to radiation has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding. Yes ____ No ____

Copies of all documents from physicians, health care providers or others relating to the exposure to radiation, or to any condition you claim is related to the exposure to radiation. Yes ____ No ____

All documents constituting, concerning or relating to product warnings or other materials provided to the individual exposed to radiation or his or her agents, representatives or anyone acting on his or her behalf (other than those provided by your attorneys in this case) in connection with the exposure to radiation. Yes ____ No ____

Any releases, covenants not to sue, or any other agreement(s) between you and any other person or entity relating in any way to the claims asserted in this lawsuit. Yes ___ No ____

All press releases or other public statements made by or on behalf of you relating to this litigation. Yes ____ No ____

All documents recording any communications concerning radiation exposure that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, manufacturer or distributor, members of the press or news media, or other person (other than your lawyers in this case). Yes ____ No ____

All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation. Yes ____ No ____

All documents relating to radiation exposure or any alleged health risks or hazards related to radiation exposure in your possession at or before the time of the injury alleged in your Complaint. Yes ____ No ____

All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant. Yes ____ No ____

All photographs, drawings, journals, slides or videos relating to the injuries alleged in your Complaint. Yes ____ No ____

If you are claiming lost wages or loss of earning capacity, any documents that refer, reflect, or relate to your past, present, or future earnings and earnings capacity, including but not limited to W-2s, 1099s, K-1s, tax returns, pay stubs, from the last 10 years. Yes ___ No ___

All documents that record, reflect, or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the radiation exposure as alleged in the Complaint. Yes ____ No ____

Copies of any materials referring or relating to CT scans and/or radiation dose that you received or reviewed before or after the CT scan(s) that you claim exposed you to radiation. Yes ____ No ____

Any diary entries, calendar entries, date book entries or other documents (including files maintained electronically) that reflect any alleged symptom, adverse reaction, or other injury resulting from the exposure to radiation during a CT scan(s). Yes ____ No ____

All documents referring or relating to any benefits, including, without limitation, medical insurance benefits, Social Security disability benefits or any other disability benefits that you filed for, received, or was denied in connection with any injury or illness. Yes ____ No ____

All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from GE, other than documents produced by GE in this litigation. Yes ____ No ____

All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from a Healthcare Provider, other than documents produced in this litigation. Yes ____ No ____

All documents in your possession, or in the possession of your attorney, that you or your attorneys obtained from the hospital where you had the CT scan(s) where you were exposed to radiation or from the physician or radiologist prescribing the scan. Yes ____ No ____

Decedent's death certificate (if applicable). Yes ____ No ____

Report of autopsy of decedent (if applicable). Yes ____ No ____

Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes ____ No ____

Copies of guardianship papers, power of attorney, or other documents that confer upon you the authority to act on behalf of the person exposed to radiation during a CT on a GE CT Scanner. Yes ____ No ____

AUTHORIZATIONS

Complete and sign the attached authorizations for the release of records.

VERIFICATION

I declare under penalty of perjury that the information provided in this plaintiff's fact sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in this plaintiff's fact sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respect incomplete or incorrect.

_____
Signature

_____
Printed Name

_____
Date